

CONFIDENTIAL SCHOOL INCIDENT INVESTIGATION

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SEND COMPLETED REPORT TO DISTRICT OFFICE

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL
ATTORNEY/CLIENT PRIVILEGE

District Name		School/Site	
Name (<i>Last, First, M.I.</i>):		<input type="checkbox"/> Student	<input type="checkbox"/> Non-Student
Homes Address Street, City, ST, Zip		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Home Phone No.:		Date of Incident:	Time:
Report to Whom?		Date Reported:	Time:

DETAILS OF INCIDENT

Exact Location of Incident

Did incident involve other student(s) or non-student(s)? Yes No If "Yes," Give Name(s):

DESCRIBE HOW THE INCIDENT OCCURRED IN DETAIL (ATTACH ADDITIONAL SHEET OR REPORT IF NECESSARY)

WAS EQUIPMENT OR MACHINERY INVOLVED? (PLAYGROUND, INDUSTRIAL ARTS, ETC.) Yes No If "YES," NOTE ANY DEFICIENCIES

WAS A RULE OR PROCEDURE VIOLATED? EXPLAIN (Include horseplay)

Full Name of Teacher, Teacher's Aide, etc., for injured student	Title of Person (Teacher, Aide, etc.)	Present at time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Witness	Address	Phone
		Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Witness	Address	Phone
		Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Witness	Address	Phone
		Status: <input type="checkbox"/> Teacher <input type="checkbox"/> Parent <input type="checkbox"/> Student <input type="checkbox"/> Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No

NATURE OF INJURY	INJURED PART OF BODY
<input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Other - Explain below:	<input type="checkbox"/> Left Side <input type="checkbox"/> Right Side <input type="checkbox"/> Abdomen <input type="checkbox"/> Arm <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Leg <input type="checkbox"/> Neck <input type="checkbox"/> Other pain/discomfort - Explain below:

First Aid Treatment Given: _____ Name of person who administered First Aid: _____

Parent/Guardian Name _____ Date/time Contacted _____ Disposition Return to Class Home Doctor 911/Hospital
 Other _____ Transported By: _____

Parent attitude or other comments

REPORT PREPARED BY	TITLE	PHONE NUMBER	DATE PREPARED

SITE ADMINISTRATOR SIGNATURE

CONFIDENTIAL ATTORNEY/CLIENT PRIVILEGE

INCIDENT REPORT

Student's Name: _____ Date of Incident: _____

Attending Teacher: _____

Details of Incident: _____

Site Response/First Aid Given: _____

Follow-up (if applicable): _____

Parent Contacted: _____

Teacher/Site Administrator Signature: _____